

PART 5

EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) SERVICES

	<u>Section</u>	<u>Page</u>
<u>Introduction</u>		
Overview	5010	5-3
<u>Program Requirements and Methods</u>		
Basic Requirements	5110	5-5
Informing Families of EPSDT Services	5121	5-7
EPSDT Service Requirements	5122	5-9
Screening Service Delivery and Content	5123	5-10
Minimum Standards and Requirements	5123.1	5-10
Screening Service Content	5123.2	5-11
Diagnosis and Treatment	5124	5-17
Periodicity Schedule	5140	5-19
Transportation and Scheduling Assistance (Support Services)	5150	5-20
<u>Utilization of Providers and Coordination with Related Programs</u>		
Utilization of Providers	5220	5-25
Coordination with Related Agencies and Programs	5230	5-27
Relations With State Maternal and Child Health (MCH) Programs	5230.1	5-28
Other Agencies and Programs	5230.2	5-30
Continuing Care	5240	5-33
<u>Administration</u>		
Program Monitoring, Planning, and Evaluation	5310	5-35
Information Needs and Reporting	5320	5-38
Administrative Information Requirements	5320.1	5-38
Records or Information on Services and Recipients	5320.2	5-38
Timeliness	5330	5-45
Reimbursement	5340	5-51
Confidentiality	5350	5-55
Annual Participation Goals	5360	5-56

Introduction

5010. OVERVIEW

A. Early and Periodic Screening, Diagnostic and Treatment Benefit.--Early and periodic screening, diagnostic and treatment services (EPSDT) is a required service under the Medicaid program for categorically needy individuals under age 21. The EPSDT benefit is optional for the medically needy population. However, if the EPSDT benefit is elected for the medically needy population, the EPSDT benefit must be made available to all Medicaid eligible individuals under age 21.

B. A Comprehensive Child Health Program.--The EPSDT program consists of two, mutually supportive, operational components:

- o assuring the availability and accessibility of required health care resources and
- o helping Medicaid recipients and their parents or guardians effectively use them.

These components enable Medicaid agencies to manage a comprehensive child health program of prevention and treatment, to systematically:

- o Seek out eligibles and inform them of the benefits of prevention and the health services and assistance available,
- o Help them and their families use health resources, including their own talents and knowledge, effectively and efficiently,
- o Assess the child's health needs through initial and periodic examinations and evaluation, and
- o Assure that health problems found are diagnosed and treated early, before they become more complex and their treatment more costly. Although "case management" does not appear in the statutory provisions pertaining to the EPSDT benefit, the concept has been recognized as a means of increasing program efficiency and effectiveness by assuring that needed services are provided timely and efficiently, and that duplicated and unnecessary services are avoided.

C. Administration.--You have the flexibility within the Federal statute and regulations to design an EPSDT program that meets the health needs of recipients within your jurisdiction. Title XIX establishes the framework, containing standards and requirements you must meet.

Program Requirements and Methods

5110. BASIC REQUIREMENTS

OBRA 89 amended §§1902(a)(43) and 1905(a)(4)(B) and created §1905(r) of the Social Security Act (the Act) which set forth the basic requirements for the program. Under the EPSDT benefit, you must provide for screening, vision, hearing and dental services at intervals which meet reasonable standards of medical and dental practice established after consultation with recognized medical and dental organizations involved in child health care. You must also provide for medically necessary screening, vision, hearing and dental services regardless of whether such services coincide with your established periodicity schedules for these services. Additionally, the Act requires that any service which you are permitted to cover under Medicaid that is necessary to treat or ameliorate a defect, physical and mental illness, or a condition identified by a screen, must be provided to EPSDT participants regardless of whether the service or item is otherwise included in your Medicaid plan.

The statute provides an exception to comparability for EPSDT services. Under this exception, the amount, duration and scope of the services provided under the EPSDT program are not required to be provided to other program eligibles or outside of the EPSDT benefit. Services under EPSDT must be sufficient in amount, duration, or scope to reasonably achieve their purpose. The amount, duration, or scope of EPSDT services to recipients may not be denied arbitrarily or reduced solely because of the diagnosis, type of illness, or condition. Appropriate limits may be placed on EPSDT services based on medical necessity.

5121. INFORMING FAMILIES OF EPSDT SERVICES

A. General Information.--Section 1902(a)(43) of the Act requires that the State plan provide for informing all eligible Medicaid recipients under 21 about EPSDT. The intent of the statute is to allow flexibility of process as long as the outcome is effective, and is achieved in a timely manner, generally within 60 days.

The informing process, which may begin at the intake interview, extends to no later than 60 days following the date of a family's or individual's initial eligibility determination, or of a determination after a period of ineligibility. A combination of face-to-face, oral, and written informing activities is most productive.

The regulation requires you to assure that your combination of written and oral informing methods are effective. Use methods of communication that recipients can clearly and easily understand to ensure that they have the information they need to utilize services to which they are entitled. HCFA considers "oral" methods to include face-to-face informing by eligibility case workers, health aides and providers as well as public service announcements, community awareness campaigns, audio-visual films and film strips.

It is effective and efficient to target specific informing activities to particular "at risk" groups. For example, mothers with babies to be added to assistance units, families with infants, or adolescents, first time eligibles, and those not using the program for over 2 years might benefit most from oral methods.

B. Individuals to Be Informed.--

- o Inform all Medicaid-eligible families about the EPSDT program.
- o Inform newly eligible families, either determined eligible for the first time, or determined eligible after a period of ineligibility if they have not used EPSDT services for at least 1 year. Use a combination of written and oral methods, generally within 60 days following the date of the eligibility determination.

Families that go on and off the rolls do not have to be informed more than once in a 12-month period.

- o There is no distinction between title IV-E foster care families and others. For title IV-E foster care individuals, informing must be with the unit receiving the cash assistance (e.g., foster parent, administrator of institution). Many title IV-E foster care individuals are rotated frequently through foster care homes or institutions, and, in some cases, there are changes in foster parents, institution administrators, or responsible social workers. It is to the individual's benefit that informing be done initially, not only with the unit receiving the cash assistance, but with parties who have legal authority over or custody of the individual.

Informing about EPSDT encourages appropriate planning for the health needs of children. When informing foster parents or administrators of institutions encompass all title IV-E foster care individuals in their care. Inform institutions or homes having a number of individuals annually or more often when the need arises, such as when changes in administrators, social workers or foster parents occur. If an individual is rotated through foster care homes, inform the responsible parties at the homes, unless previously done within the year for other foster care individuals. Annual contact establishes a relationship with the facilities to resolve any problems arising.

- o Inform a Medicaid eligible pregnant woman about the availability of EPSDT services for children under age 21 (including children eligible as newborns). A Medicaid eligible woman's positive response to an offer of EPSDT services during her pregnancy, which is medically confirmed, constitutes a request for EPSDT services for the child at birth. For a child eligible at birth (i.e., as a newborn of a woman who is eligible for and receiving Medicaid), the request for EPSDT services is effective with the birth of the child. The parent or guardian of an infant who is not deemed eligible at birth as a newborn must be informed at the time the infant's eligibility is determined.

C. Content and Methods.--

- o Use clear and nontechnical language, provide a combination of oral and written methods designed to inform all eligible individuals (or their families) effectively describing what services are available under the EPSDT program; the benefits of preventive health care, where the services are available, how to obtain them; and that necessary transportation and scheduling assistance is available.

Inform eligible individuals whether services are provided without cost. States may impose premiums for Medicaid on individuals (i.e., pregnant women and infants) whose family income exceeds 150 percent of Federal poverty levels as described in §3571 and, for medically needy participants, may impose enrollment fees, premiums or similar charges for participation in the medically needy program.

- o Provide assurance that processes are in place to effectively inform individuals, generally within 60 days of the individual's Medicaid eligibility determination and, if no one eligible in the family has utilized EPSDT services, annually thereafter.

- o Utilize accepted methods for informing persons who are illiterate, blind, deaf, or cannot understand the English language. For assistance in developing appropriate procedures, contact agencies with established procedures for working with such individuals, e.g., State or local education departments, employment security offices, handicapped programs.

- o You have the flexibility to determine how information may be given most appropriately while assuring that every EPSDT eligible receives the basic information necessary to gain access to EPSDT services.

5122. EPSDT SERVICE REQUIREMENTS

The EPSDT benefit, in accordance with §1905(r) of the Act, must include the services set forth below. The frequency with which the services must be provided is discussed in §5140.

A. Screening Services.--Screening services include all of the following services:

- o A comprehensive health and developmental history (including assessment of both physical and mental health development);
- o A comprehensive unclothed physical exam;
- o Appropriate immunizations (according to the schedule established by the Advisory Committee on Immunization Practices (ACIP) for pediatric vaccines);
- o Laboratory tests (including blood lead level assessment appropriate to age and risk);
- o Health education (including anticipatory guidance).

Immunizations which may be appropriate based on age and health history but which are medically contraindicated at the time of the screening may be rescheduled at an appropriate time. The ACIP schedule is included in §5123.2.C.

B. Vision Services.--At a minimum, include diagnosis and treatment for defects in vision, including eyeglasses.

C. Dental Services.--At a minimum, include relief of pain and infections, restoration of teeth and maintenance of dental health. Dental services may not be limited to emergency services.

D. Hearing Services.--At a minimum, include diagnosis and treatment for defects in hearing, including hearing aids.

E. Other Necessary Health Care.--Provide other necessary health care, diagnostic services, treatment, and other measures described in §1905(a) of the Act to correct or ameliorate defects, and physical and mental illnesses and conditions discovered by the screening services.

F. Limitation of Services.--The services available in subsection E are not limited to those included in your State plan.

Under subsection E, the services must be "necessary . . . to correct or ameliorate defects and physical or mental illnesses or conditions . . ." and the defects, illnesses and conditions must have been discovered or shown to have increased in severity by the screening services. You make the determination as to whether the service is necessary. You are not required to provide any items or services which you determine are not safe and effective or which are considered experimental.

42 CFR 440.230 allows you to establish the amount, duration and scope of services provided under the EPSDT benefit. Any limitations imposed must be reasonable and services must be sufficient to achieve their purpose (within the context of serving the needs of individuals under age 21). You may define the service as long as the definition comports with the requirements of the statute in that all services included in §1905(a) of the Act that are medically necessary to ameliorate or correct defects and physical or mental illnesses and conditions discovered by the screening services are provided.

All services must be provided in accordance with both §1905(a) of the Act and any State laws of general applicability that govern the provision of health services. Home and community based services which are authorized by §1915(c) of the Act are not included among the other health care under subsection E because these services are not included under §1905(a) of the Act.

5123. SCREENING SERVICE DELIVERY AND CONTENT

5123.1 Minimum Standards and Requirements.--

A. State Standards.--Set standards and protocols which, at a minimum, meet the standards of §1905(r) of the Act for each component of the EPSDT services, and maintain written evidence of them. The standards must provide for services at intervals which meet reasonable standards of medical and dental practice and be established after consultation with recognized medical and dental organizations involved in child health care. The standards must also provide for EPSDT services at other intervals, indicated as medically necessary, to determine the existence of certain physical or mental illnesses or conditions. The intervals at which services must be made available are discussed in §5140.

B. Services.--Provide an eligible individual requesting EPSDT services required screening services listed in §5122. This initial examination(s) may be requested at any time, and must be provided without regard to whether the individual's age coincides with the established periodicity schedule. Sound medical practice requires that when children first enter the EPSDT program you encourage and promote that they receive the full panoply of screening services available under EPSDT.

It is desirable that a parent or other responsible adult accompany the child to the examination. When this is not possible or practical, arrange for a follow-up worker, social worker, health aide, or neighborhood worker to discuss the results in a visit to the home or in contacts with the family elsewhere.

C. Who Screens/Assesses?--

o Examinations are performed by, or under the supervision of, a certified Medicaid physician, dentist, or other provider qualified under State law to furnish primary medical and health services. These services may be provided within State and local health departments, school health programs, programs for children with special health needs, Maternity and Infant Care projects, Children and Youth programs, Head Start programs, community health centers, medical/dental schools, prepaid health care plans, a private practitioner and any other licensed practitioners in a variety of arrangements.

o The use of all types of providers is encouraged. Recipients should have the greatest possible range and freedom of choice. It is required, in the case of title V, and encouraged, in the case of the primary care projects (i.e., community health centers), that maximum use be made of these providers. Day care centers may provide sites for examination activities. Encourage cooperation when and where other broad-based assessment programs are unavailable.

o Providers may not be limited to those which have an exclusive contract to perform all EPSDT services. Service providers may not be limited to either the private or public sector or because the provider may not offer all EPSDT services or because it offers only one service. Assure maximum utilization of existing resources to more effectively administer and deliver services.

Medicaid providers who offer EPSDT examination services must assure that the services they provide meet the agency's minimum standards for those services in order to be reimbursed at the level established for EPSDT services.

5123.2 Screening Service Content.--

A. Comprehensive Health and Developmental History.--Obtain this information from the parent or other responsible adult who is familiar with the child's history and include an assessment of both physical and mental health development. Coupled with the physical examination, this includes:

1. Developmental Assessment.--This includes a range of activities to determine whether an individual's developmental processes fall within a normal range of achievement according to age group and cultural background. Screening for developmental assessment is a part of every routine initial and periodic examination.

Developmental assessment is also carried out by professionals to whom children are referred for structured tests and instruments after potential problems have been identified by the screening process. You may build the two aspects into the program so that fewer referrals are made for additional developmental assessment.

a. Approach.--There is no universal list of the dimensions of development for the different age ranges of childhood and adolescence. In younger children, assess at least the following elements:

- o Gross motor development, focusing on strength, balance, locomotion;
- o Fine motor development, focusing on eye-hand coordination;
- o Communication skills or language development, focusing on expression, comprehension, and speech articulation;
- o Self-help and self-care skills;
- o Social-emotional development, focusing on the ability to engage in social interaction with other children, adolescents, parents, and other adults; and
- o Cognitive skills, focusing on problem solving or reasoning.

As the child grows through school age, focus the program on visual-motor integration, visual-spatial organization, visual sequential memory, attention skills auditory processing skills, and auditory sequential memory. Most school systems provide routines and resources for developmental screening.

For adolescents, the orientation should encompass such areas of special concern as potential presence of learning disabilities, peer relations, psychological/psychiatric problems, and vocational skills.

b. Procedures.--No list of specified tests and instruments is prescribed for identifying developmental problems because of the large number of such instruments, development of new approaches, the number of children and the complexity of developmental problems which occur, and to avoid any connotation that only certain tests or instruments satisfy Federal requirements. However, the following principles must be considered:

- o Acquire information on the child's usual functioning, as reported by the child, parent, teacher, health professional, or other familiar person.

- o In screening for developmental assessment, the examiner incorporates and reviews this information in conjunction with other information gathered during the physical examination and makes an objective professional judgement whether the child is within the expected ranges. Review developmental progress, not in isolation, but as a component of overall health and well-being, given the child's age and culture.

- o Developmental assessment should be culturally sensitive and valid. Do not dismiss or excuse improperly potential problems on grounds of culturally appropriate behavior. Do not initiate referrals improperly for factors associated with cultural heritage.

- o Programs should not result in a label or premature diagnosis of a child. Providers should report only that a condition was referred or that a type of diagnostic or treatment service is needed. Results of initial screening should not be accepted as conclusions and do not represent a diagnosis.

- o Refer to appropriate child development resources for additional assessment, diagnosis, treatment or follow-up when concerns or questions remain after the screening process.

2. Assessment of Nutritional Status.--This is accomplished in the basic examination through:

- o Questions about dietary practices to identify unusual eating habits (such as pica or extended use of bottle feedings) or diets which are deficient or excessive in one or more nutrients.

- o A complete physical examination including an oral dental examination. Pay special attention to such general features as pallor, apathy and irritability.

- o Accurate measurements of height and weight, which are among the most important indices of nutritional status.

- o A laboratory test to screen for iron deficiency. HCFA and PHS recommend that the erythrocyte protoporphyrin (EP) test be utilized when possible for children ages 1-5. It is a simple, cost effective tool for screening for iron deficiency. Where the EP test is not available, use hemoglobin concentration or hematocrit.

- o If feasible, screen children over 1 year of age for serum cholesterol determination, especially those with a family history of heart disease and/or hypertension and stroke.

If information suggests dietary inadequacy, obesity or other nutritional problems, further assessment is indicated, including:

- o Family, socioeconomic or any community factors,

- o Determining quality and quantity of individual diets (e.g., dietary intake, food acceptance, meal patterns, methods of food preparation and preservation, and utilization of food assistance programs),
- o Further physical and laboratory examinations, and
- o Preventive, treatment and follow-up services, including dietary counseling and nutrition education.

B. Comprehensive Unclothed Physical Examination.--This includes the following:

1. Physical Growth.--Record and compare the child's height and weight with those considered normal for that age. (In the first year of life, head circumference measurements are important). Use a graphic recording sheet to chart height and weight over time.

2. Unclothed Physical Inspection.--Check the general appearance of the child to determine overall health status. This process can pick up obvious physical defects, including orthopedic disorders, hernia, skin disease, and genital abnormalities. Physical inspection includes an examination of all organ systems such as pulmonary, cardiac, and gastrointestinal.

C. Appropriate Immunizations.--Assess whether the child has been immunized against diphtheria, pertussis, tetanus, polio, measles, rubella, mumps, haemophilus influenzae type b conjugate (Hib), hepatitis B, and varicella zoster (chickenpox); and whether booster shots are needed. The child's immunization record should be available to the provider. When an immunization or an updating is medically necessary and appropriate, provide it and inform the child's health supervision provider.

Provide immunizations as recommended by the Advisory Committee on Immunization Practices (ACIP) on the next page.

The ACIP recommendations as indicated on the next page will be used to determine when Federal financial participation is not available for single antigen vaccines (unless a combined antigen vaccine was medically contraindicated).

Pages 5-14.1 and 5-14.2 are reserved for
Figure 1--Recommended
Childhood Vaccination Schedule--United States,
January-June 1996

D. Appropriate Laboratory Tests.--Identify as statewide screening requirements the minimum laboratory tests or analyses to be performed by medical providers for particular age or population groups. Physicians providing screening/assessment services under the EPSDT program use their medical judgment in determining the applicability of the laboratory tests or analyses to be performed. If any laboratory tests or analyses are medically contraindicated at the time of screening/assessment, provide them when no longer medically contraindicated. As appropriate, conduct the following laboratory tests.

1. Lead Toxicity Screening.--All children ages 6 months to 72 months are considered at risk and must be screened for lead poisoning. HCFA now requires the use of the blood lead test when screening children for lead poisoning. The erythrocyte protoporphyrin test is no longer acceptable as a screening test for lead poisoning. Each State establishes its own periodicity schedule after consultation with medical organizations involved in child health. These periodicity schedules and any other associated office visits must be used as an opportunity for anticipatory guidance and risk assessment for lead poisoning.

a. Risk Assessment.--All children from 6 to 72 months of age are considered at risk and must be screened. Beginning at 6 months of age and at each visit thereafter, the provider must discuss with the child's parent or guardian childhood lead poisoning interventions and assess the child's risk for exposure. Ask the following types of questions at a minimum:

o Does your child live in or regularly visit an old house built before 1960? Was your child's day care center/preschool/babysitter's home built before 1960? Does the house have peeling or chipping paint?

o Does your child live in a house built before 1960 with recent, ongoing or planned renovation or remodeling?

o Have any of your children or their playmates had lead poisoning?

o Does your child frequently come in contact with an adult who works with lead? Examples are construction, welding, pottery, or other trades practiced in your community.

o Does your child live near a lead smelter, battery recycling plant, or other industry likely to release lead such as (give examples in your community)?

o Do you give your child any home or folk remedies which may contain lead?

o Does your child live near a heavily travelled major highway where soil and dust may be contaminated with lead?

o Does your home's plumbing have lead pipes or copper with lead solder joints?

Ask any additional questions that may be specific to situations which exist in a particular community.

b. Determining Risk.--Risk is determined from the response to the questions which your State requires for verbal risk assessment.

If the answers to all questions are negative, a child is considered low risk for high doses of lead exposure, but must receive blood lead screening by blood lead test at 12 months of age and 24 months of age.

If the answer to any question is positive, a child is considered high risk for high doses of lead exposure. A blood lead test must be obtained at the time a child is determined to be high risk.

Subsequent verbal risk assessments can change a child's risk category. If as the result of a verbal risk assessment a previously low risk child is recategorized as high risk, that child must be given a blood lead test.

c. Screening Blood Tests.--The term screening blood tests refers to blood tests for children who have not previously been tested for lead with a blood lead test or who have been previously tested and found not to have an elevated blood lead level. If a child is determined by the verbal risk assessment to be at:

(1) Low Risk.--A screening blood lead test is required at 12 months of age and a second blood lead test at 24 months of age.

(2) High Risk.--A blood lead test is required when a child is identified as being high risk, beginning at six months of age. If the initial blood lead test results are less than 10 micrograms per deciliter (ug/dL), a screening blood lead test is required at every visit prescribed in your EPSDT periodicity schedule through 72 months of age, unless the child has already received a blood lead test within the last six months of the periodic visit.

A blood lead test result equal to or greater than 10 ug/dL obtained by capillary specimen (fingerstick) must be confirmed using a venous blood sample.

If a child between the ages of 24 months and 72 months has not received a screening blood lead test, then that child must receive it immediately, regardless of being determined at low or high risk.

d. Diagnosis, Treatment and Follow-Up.--If a child is found to have blood lead levels equal to or greater than 10 ug/dL, providers are to use their professional judgment, with reference to CDC guidelines covering patient management and treatment, including follow up blood tests and initiating investigations to determine the source of lead, where indicated. Determining the source of lead may be reimbursable by Medicaid.

e. Coordination With Other Agencies.--Coordination with WIC, Head Start, and other private and public resources enables elimination of duplicate testing and ensures comprehensive diagnosis and treatment. Also, public health agencies' childhood lead poisoning prevention programs may be available. These agencies may have the authority and ability to investigate a lead-poisoned child's environment and to require remediation.

2. Anemia Test.--The most easily administered test for anemia is a microhematocrit determination from venous blood or a fingerstick.

3. Sickle Cell Test.--Diagnosis for sickle cell trait may be done with sickle cell preparation or a hemoglobin solubility test. If a child has been properly tested once for sickle cell disease, the test need not be repeated.

4. Tuberculin Test.--Give a tuberculin test to every child who has not received one within a year.

5. Others.--In addition to the tests above, there are several other tests to consider. Their appropriateness are determined by an individual's age, sex, health history, clinical symptoms and exposure to disease. These include a urine screening, pinworm slide, urine culture (for girls), serological test, drug dependency screening, stool specimen for parasites, ova, blood, and HIV screening.

E. Health Education.--Health education is a required component of screening services and includes anticipatory guidance. At the outset, the physical and dental assessment, or screening, gives you the initial context for providing health education. Health education and counselling to both parents (or guardians) and children is required and is designed to assist in understanding what to expect in terms of the child's development and to provide information about the benefits of healthy lifestyles and practices as well as accident and disease prevention.

F. Vision and Hearing Screens.--Vision and hearing services are subject to their own periodicity schedules (as described in §5140). However, where the periodicity schedules coincide with the schedule for screening services (defined in §5122A), you may include vision and hearing screens as a part of the required minimum screening services.

1. Appropriate Vision Screen.--Administer an age-appropriate vision assessment. Consultation by ophthalmologists and optometrists can help determine the type of procedures to use and the criteria for determining when a child is referred for diagnostic examination.

2. Appropriate Hearing Screen.--Administer an age-appropriate hearing assessment. Obtain consultation and suitable procedures for screening and methods of administering them from audiologists, or from State health or education departments.

G. Dental Screening Services.--Although an oral screening may be part of a physical examination, it does not substitute for examination through direct referral to a dentist. A direct dental referral is required for every child in accordance with your periodicity schedule and at other intervals as medically necessary. Prior to enactment of OBRA 1989, HCFA in consultation with the American Dental Association, the American Academy of Pediatrics and the American Academy of Family Practice, among other organizations, required direct referral to a dentist beginning at age 3 or an earlier age if determined medically necessary. The law as amended by OBRA 1989 requires that dental services (including initial direct referral to a dentist) conform to your periodicity schedule which must be established after consultation with recognized dental organizations involved in child health care.

Especially in older children, the periodicity schedule for dental examinations is not governed by the schedule for medical examinations. Dental examinations of older children should occur with greater frequency than is the case with physical examinations. The referral must be for an encounter with a dentist, or a professional dental hygienist under the supervision of a dentist, for diagnosis and treatment. However, where any screening, even as early as the neonatal examination, indicates that dental services are needed at an earlier age, provide the needed dental services.

The requirement of a direct referral to a dentist can be met in settings other than a dentist's office. The necessary element is that the child be examined by a dentist or other dental professional under the supervision of a dentist. In an area where dentists are scarce or not easy to reach, dental examinations in a clinic or group setting may make the service more appealing to recipients while meeting the dental periodicity schedule. If continuing care providers have dentists on their staff, the direct referral to a dentist requirement is met. Dental paraprofessionals under direct supervision of a dentist may perform routine services when in compliance with State practice acts.

Determine whether the screening provider or the agency does the direct referral to a dentist. You are ultimately responsible for assuring that the direct referral is made and that the child gets to the dentist's office in a timely manner.

5124. DIAGNOSIS AND TREATMENT

A. Diagnosis.--

1. When.--When a screening examination indicates the need for further evaluation of an individual's health, provide diagnostic studies. Make the referral for diagnosis without delay, and follow-up to make sure that the recipient receives a complete diagnostic evaluation. If the recipient is receiving care from a continuing care provider, diagnosis may be part of the screening and examination process. Develop quality assurance procedures to assure comprehensive care for the individual.

2. By Whom.--An individual's diagnosis may be performed by a:

- o Physician;
- o Maternal and Child Health (MCH) facility;
- o Community health center;
- o Rehabilitation center;
- o Hospital outpatient department; or
- o Other practitioner or facility qualified to evaluate and diagnose an individual's health problem.

3. As Outpatient or Inpatient.--Diagnosis can usually be accomplished on an outpatient basis. Where inpatient services are necessary to complete the diagnosis, provide them.

4. Services.--You must make available to recipients diagnostic services which are necessary to fully evaluate defects and physical or mental illnesses or conditions discovered by the screening services.

B. Treatment.--

1. General. - You must make available health care, treatment or other measures to correct or ameliorate defects and physical and mental illnesses or conditions discovered by the screening services. Treatment services may be limited as described in §5122 F.

2. Required Vision and Hearing Treatment, Dental Care. - You must provide the following services:

a. Treatment for defects in vision and hearing, including provision of eyeglasses and hearing aids.

b. Dental care, at as early an age as necessary, needed for relief of pain infections, restoration of teeth, and maintenance of dental health. Dental care includes emergency and preventive services and therapeutic services for dental disease which, if left untreated, may become acute dental problems or may cause irreversible damage to the teeth or supporting structures. For further information, consult HCFA's Guide to Dental Care, EPSDT- Medicaid, prepared in cooperation with the American Society of Dentistry for Children and the American Academy of Pedodontics (HCFA Pub. No. 24515).

o Emergency Services are those necessary to control bleeding, relieve pain, eliminate acute infection; operative procedures which are required to prevent pulpal death and the imminent loss of teeth; treatment of injuries to the teeth or supporting structures (e.g., bone or soft tissues contiguous to the teeth); and palliative therapy for pericoronitis associated with impacted teeth. You may not limit dental services to emergency services.

Routine restorative procedures and root canal therapy are not emergency services.

o Preventive Services, provided either individually or in groups, include:

- Instruction in self-care oral hygiene procedures;
- Oral prophylaxis (cleaning of teeth), both necessary as a precursor to the application of dental caries preventives where indicated, or independent of the application of caries preventives for patients 10 years of age or older; and

- Professional application of dental sealants when appropriate to prevent pit and fissure caries.

o Therapeutic Services include:

- Pulp therapy for permanent and primary teeth;
- Restoration of carious (decayed) permanent and primary teeth with silver amalgam, silicate cement, plastic materials and stainless steel crowns;
- Scaling and curettage;
- Maintenance of space for posterior primary teeth lost permanently;
- Provision of removable prosthesis when masticatory function is impaired, or when existing prosthesis is unserviceable. It may include services when the condition interferes with employment training or social development; and

- Orthodontic treatment when medically necessary to correct handicapping malocclusion.

c. Appropriate Immunizations.--If it is determined at the time of screening that immunization is needed and appropriate, then immunization must be provided at that time.

3. Prenatal Care Services.--Just as it can provide enhanced services for at-risk infants, EPSDT can link at-risk adolescents to pre-pregnancy risk education, family planning, pregnancy testing and prenatal care. It is important that all pregnant women obtain early prenatal care and that they and newborns be cared for in a setting that provides quality services appropriate to their level of risk. Late care or no care is related to increased prematurity rates. Low birth weight is the most important predictor of illness or death in early infancy. Higher costs of care are associated with the need for neonatal intensive care, extended and repeated hospitalizations, and followup services for these infants born at risk.

Provide nurse-midwife services in pregnancy, labor, birth, and the immediate postpartum period to the categorically needy, to the extent that they are legally authorized to practice. Offer direct reimbursement to nurse-midwives as one of the payment options.

- Orthodontic treatment when medically necessary to correct handicapping malocclusion.

c. Appropriate Immunizations.--If it is determined at the time of screening that immunization is needed and appropriate, immunization must be provided at that time.

3. Prenatal Care Services.--Just as it can provide enhanced services for at-risk infants, EPSDT can link at-risk adolescents to pre-pregnancy risk education, family planning, pregnancy testing, and prenatal care. It is important that all pregnant women obtain early prenatal care and that they and newborns be cared for in a setting that provides quality services appropriate to their level of risk. Late care or no care is related to increased prematurity rates. Low birth weight is the most important predictor of illness or death in early infancy. Higher costs of care are associated with the need for neonatal intensive care, extended and repeated hospitalizations, and follow up services for infants born at risk.

Provide nurse midwife services in pregnancy, labor, birth, and the immediate postpartum period to the categorically needy to the extent that nurse midwives are legally authorized to practice. Offer direct reimbursement to nurse midwives as one of the payment options.

5140. PERIODICITY SCHEDULE

A. Requirements for Periodic Screening, Vision, Hearing, and Dental Services.--Distinct periodicity schedules must be established for screening services, vision services, hearing services, and dental services (i.e., each of these services must have its own periodicity schedule).

Screening, vision, and hearing services must be provided at intervals which meet reasonable standards of medical practice. You must consult with recognized medical organizations involved in child health care in developing reasonable standards.

Dental services must be provided at intervals you determine meet reasonable standards of dental practice. You must consult with recognized dental organizations involved in child health care to establish those intervals. A direct dental referral is required for every child in accordance with your periodicity schedule and at other intervals as medically necessary. Prior to enactment of OBRA 1989, HCFA, in consultation with the American Dental Association, the American Academy of Pediatrics, and the American Academy of Family Practice (as well as other organizations), required direct referral to a dentist beginning at age 3 or an earlier age if determined medically necessary. The law as amended by OBRA 1989 requires that dental services (including initial, direct referral to a dentist) conform to your periodicity schedule, which must be established after consultation with recognized dental organizations involved in child health care. The periodicity schedule for other EPSDT services may not govern the schedule for dental services. It is expected that older children may require dental services more frequently than physical examinations.

B. Requirements for Interperiodic Screenings.--You must provide for interperiodic screening, vision, hearing, and dental services which are medically necessary to determine the existence of suspected physical or mental illnesses or conditions.

The determination of whether an interperiodic screen is medically necessary may be made by a health, developmental, or educational professional who comes into contact with the child outside of the formal health care system (e.g., State early intervention or special education programs, Head Start and day care programs, the Special Supplemental Food Program for Women, Infants and Children (WIC), and other nutritional assistance programs). For example, a child is screened at age 5 according to your periodicity schedule for vision services and is found to have no abnormalities. At age 6, the child is referred to the school nurse by a teacher who suspects the child has a vision problem. The screening indicates a problem may exist. If the child is referred to a qualified provider of vision care, the services must be covered even though under your periodicity schedule vision services may not be required until the child reaches age 7.

C. General Information.--Sections 1905(a)(4)(B) and 1905(r) of the Act require periodicity schedules to assure that at least a minimum number of health examinations occur at critical points in a child's life. In addition, §1905(r) of the Act requires that medically necessary interperiodic screens be provided.

The periodicity schedule provides a minimum basis for follow-up assessments after initial examination. Examinations must be provided with reasonable promptness to new eligibles after their initial requests. There is flexibility to strengthen the preventive nature of the program by providing screening, diagnostic, and treatment services between otherwise scheduled examinations. Implement periodicity schedules only up to the age at which individuals are no longer eligible.

5150. TRANSPORTATION AND SCHEDULING ASSISTANCE (SUPPORT SERVICES)

To ensure that recipients obtain needed Medicaid services, offer and provide, if requested and necessary, assistance with transportation and scheduling appointments.

Distinguish between a request for EPSDT health care services and a request for support services. A request for health care services under the program implies a request only for the EPSDT services listed in §§5110-5140. Once a request for support services for EPSDT has been made, assume it applies to both the examination and follow-up diagnostic and treatment services.

Offer both transportation and scheduling assistance prior to each due date of a child's periodic examination. Provide this assistance if requested and necessary.

42 CFR 431.53 requires that your plan specify responsibility for the necessary transportation of recipients to and from providers of services and describes the methods to use.

THE NEXT PAGE IS 5-25

Utilization of Providers and Coordination With Related Programs

5220. UTILIZATION OF PROVIDERS

A. **General.**--Take advantage of all resources available. Make arrangements with providers, including physicians practicing in individual or group settings, for the delivery of EPSDT services. Encourage families to develop permanent provider relationships and to avoid fragmentation or duplication of services. This assures more comprehensive care for EPSDT recipients and can result in the reduction of overall health costs over time.

B. **Broad Base of Qualified Providers.**--Broaden the EPSDT provider base to include, e.g., physicians and dentists in individual and group practices, primary health care centers, community health centers, well child and rural health clinics.

Health care practitioners licensed by you may become qualified to provide EPSDT services. In some States, nurse practitioners and nurse midwives are included. Under the supervision of a physician, nurses and other health care personnel may provide a variety of EPSDT services. Judge qualifications to provide EPSDT services, recognizing applicable State practice laws and regulations.

Nothing in the Medicaid statute shall be construed as limiting providers of EPSDT services to providers who are qualified to provide all diagnostic and treatment items and services or as preventing a provider that is qualified under the plan to furnish one or more (but not all) of such items or services from being qualified to provide such items and services as part of EPSDT services.

If you elect to use providers who furnish less than the full range of screening services, encourage or promote close coordination among the screening providers, particularly where responsibility for the physical exam and the physical or mental health developmental assessment services is shared by more than one provider.

5230. COORDINATION WITH RELATED AGENCIES AND PROGRAMS

Interagency collaborative activities address several goals simultaneously:

- o Containing costs and improving services by reducing service overlaps or duplications, and closing gaps in the availability of services;
- o Focusing services on specific population groups or geographic areas in need of special attention; and
- o Defining the scope of the programs in relation to each other.

Regulations require Medicaid agencies to coordinate services with title V programs, and enter into arrangements with State agencies responsible for administering health services and vocational rehabilitation services and with title V (Maternal and Child Health) grantees.

Coordination includes child health initiatives with other related programs, such as Head Start, the Special Supplemental Food Program for Women, Infants and Children (WIC), school health programs of State and local education agencies (including the Education for all Handicapped Children Act of 1975), and social services programs under title XX.

Federal financial participation (FFP) is available to cover the costs to public agencies of providing direct support to the Medicaid agency in administering the EPSDT program.

There is no single "list of approved roles", but cooperating agencies provide a variety of outreach, screening, diagnostic or treatment services, health education and counseling, case management, facilities, funding, and other help in achieving an effective child health program. State and local program managers can help identify available child health resources and make appropriate cross referrals. Active child health coordinating committees, with representation from providers, private voluntary and public agencies are helpful in promoting cooperation in providing health services.

Written agreements are essential to effective working relationships between the Medicaid agency and agencies charged with planning, administering or providing health care to low-income families. Although agreements by themselves do not guarantee open communication and cooperation, they can lay the groundwork for collaboration and best use of each agency's resources.

Successful relationships are based upon detailed planning, clearly identified roles and responsibilities, program monitoring, periodic evaluation and revision, and constant communication. Agreements are formal documents signed by each agency's representative or written statements of understanding between units of a single department. Whatever their form, it is essential that their content be developed by all parties involved and that they provide a clear statement of each agency's responsibilities.

Each agreement must specify the participating parties, their intent, and the date upon which the agreement becomes effective, and must be signed by persons who can make it binding. Agreements need periodic review to determine if they continue to be applicable to the organization, functions, and program of the participating agencies. Reevaluate them annually and whenever a major reorganization occurs. Although the specific content of each agreement varies, they must specify:

- o The mutual objectives and responsibilities of each party to the arrangement;
- o The services each party offers and in what circumstances;
- o The cooperative and collaborative relationships at the State level;
- o The kinds of services provided by local counterparts; and
- o Methods for --
 - Early identification of individuals under 21 needing health services;
 - Reciprocal referrals;
 - Coordinating plans for health services provided or arranged for recipients;
 - Payment or reimbursement;
 - Exchange of reports of services furnished;
 - Periodic review and joint planning for changes in the agreements;
 - Continuous liaison between the parties, including designation of State and local liaison staff; and
 - Joint evaluation of policies that affect the cooperative work of the parties.

5230.1 Relations With State Maternal and Child Health (MCH) Programs.--Title V (MCH block grant) grantees and Medicaid share many of the same populations, providers, and concerns for child health. Assure that each MCH grantee and the State Medicaid agency have in effect a functional relationship via a written interagency agreement which:

- o provides for the maximum utilization of the care and services available under MCH programs; and
- o utilizes MCH grantees to develop a more effective use of Medicaid resources in financing services to Medicaid-eligible children.

The overall goal of a State MCH-Medicaid agreement is to improve the health status of children by assuring the provision of preventive services, health examinations, and the necessary treatment and follow-through care, preferably in the context of an ongoing provider-patient relationship and from comprehensive, continuing care providers. Medicaid agencies reimburse title V providers for these services even if they are provided free of charge to low-income uninsured families.

Inform recipients eligible for title V services of the available services and refer them, if they desire, to title V grantees that offer appropriate services. However, such referral does not relieve you of your obligations to assure the timely delivery of EPSDT services. For further information, consult Promoting the Health of Women and Children Through Planning, prepared by Lorraine V. Klerman, A. Yvonne Russell, and Isabelle Valadian.

A. Organization and Administration of EPSDT Programs.--HCFA encourages State programs to enlist providers who can deliver to children a broad array of services on a continuing basis. State MCH programs can help in a number of ways:

- o Recruitment of providers from both the private and public sectors to provide comprehensive, continuing care to children.
- o Provision of outreach and referral services at the local levels;
- o Utilization of Maternity and Infant Care and Children and Youth Projects, and other specialty and primary care programs as providers of comprehensive, continuing care;
- o Delegation of tasks by the Medicaid agency to the State MCH programs to assure that Medicaid-eligible children have access to and receive the full range of assessment, diagnostic, and treatment services. Such delegation can be local, regional, or Statewide.
- o Development of health services policies and standards and assessment of quality of care issues. These include implementation of professionally recognized protocols and standards of care, integration of services at local and regional levels within a State, and continuity of care. Assessment should be jointly agreed upon with a view toward: eliminating unnecessary services; duplication; providing acceptable quality of care; and integrating and providing all necessary services.
- o Assurance of continuing care. PHS-supported primary care projects provide continuing care to all child clients, regardless of their payment status. State MCH programs develop linkages with these projects to assure the full range of levels of care for mothers, infants, and children including those with special health care needs.

B. Financing and Payment Arrangements for Services Provided by or Through MCH Programs to Medicaid Beneficiaries.--Statutory authority exists in the Social Security Act for Medicaid to reimburse title V programs for the covered services they provide to Medicaid beneficiaries. Each interagency agreement refers to the services and circumstances under which Medicaid reimburses MCH programs.

Describe the payment mechanism. If it is no different than that used for other providers, merely note that the Medicaid fee schedule or reasonable charge structure is employed. Alternative payment arrangements may include:

- o Prospective interprogram transfer of funds with retrospective adjustments based upon the volume of services actually delivered;

- o Capitation payments for a pre-determined package of services; or
- o Reimbursement for actual costs.

Interagency financial arrangements may differ from the reimbursement policies employed with providers in the private sector. Limit the reimbursement of overhead costs which are above and beyond the value of vendor payments made for covered services to costs identifiable as supporting services covered through the EPSDT program. For example, a MCH program may provide diagnosis, and treatment and case management services for Medicaid-eligible children.

Outlining payment arrangements in the interagency agreement can clarify the legality of, and circumstances under which, private practitioners in the MCH program may bill through MCH for services provided to Medicaid recipients. Often services are provided in MCH settings by professionals who are not physicians; i.e., nurse practitioners, registered nurses and physician assistants. Detail the conditions under which such services are covered, such as with physician supervision, unless these coverage policies are generally applicable in the Medicaid program and are, therefore, stated elsewhere.

C. Standards of Care Established and Employed by Each Program.-- State MCH agencies have a major role in establishing standards, policies and procedures for health care services. They interpret standards to providers, provide education to enhance implementation, promote quality of care, and assess progress.

D. Mutual Program Referral Arrangements and Outreach Activities by State MCH and EPSDT Programs.--Inform and refer Medicaid recipients eligible for EPSDT services who can obtain needed services through MCH programs and who are eligible for the services of such programs. Address implementation in the interagency agreement.

5230.2 Other Agencies and Programs.--

A. Relations With State or Local Education Agencies.--The development of linkages through the family to public, private, and other community health and social services helps link existing prevention and treatment programs with those services provided in the schools. Schools can be a focal point from which to identify children with problems, to increase student's access to both preventive and curative health services, and to assure appropriate use of health care resources. Coordinating services can avoid duplicating efforts that increase costs of services and adding further stress to the child and family.

There is no single "best" way for schools to relate to EPSDT, since the populations, traditions, resources, and other factors vary greatly. For example, schools in areas with no Medicaid-eligible population do not benefit from bringing EPSDT into the schools. (For further information, see EPSDT: A Guide for Education Programs, published jointly by HCFA and the Department of Education in 1980.)

B. Relations With Head Start.--Head Start shares the same child health and development goals as EPSDT. Approximately 50 percent of Head Start families are also Medicaid families. For further information, see DHHS Publication No. (OHDS) 81-31163 issued January 1981.

C. Relations with Special Supplemental Food Program for Women, Infants and Children, Food and Nutrition Service, U.S. Department of Agriculture (WIC).--Coordination with the WIC program is required. WIC provides specific nutritious supplemental food and nutrition education at no cost to low-income pregnant, postpartum, and breastfeeding women, infants and children up to their fifth birthday. WIC serves as an adjunct to good health care. Referrals by EPSDT of all categories of WIC's target population is required.

D. Relations With Housing Programs.--Housing programs offer a physical site and focus from which services can be provided and coordinated. Often, they are locations at which related services (a public health clinic, a Head Start program) are provided.

A joint national HCFA/HUD policy statement encouraged cooperative activities between Medicaid agencies and housing authorities through written interagency agreements whereby housing authorities can make major contributions to EPSDT by assisting in outreach and referral tasks, as well as direct service roles.

E. Relations With Social Service (Title XX) Programs.--HCFA and the Office of Human Development Services jointly issued policy and planning statements to their State constituents. Title XX is a funding mechanism rather than a discrete program, and a variety of services funded under title XX are relevant to EPSDT. For example:

- o Information and Referral Services - correspond to EPSDT's outreach, scheduling, and follow-up;
- o Health-Related Services - correspond to examination services when provided through title XX-funded programs such as Day Care; and
- o Support Services - correspond to transportation, child care, escort services, health education, counseling, and staff training.

5240. CONTINUING CARE

A. **General.**--Ideally, EPSDT services are part of a continuum of care so that the child's screening services are delivered by someone familiar with his or her episodes of acute illness and who has an ongoing relationship with the family as the regular source of the child's health care. This carries out the general concept that child health services are continuing and comprehensive and that a child is able to receive examination, treatment, and referral services from one provider. Continuing care providers, such as pediatricians and other practicing physicians, HMOs, and community health centers can provide a variety of services and continuously monitor and advise parents on a child's development.

The requirement of formal enrollment with a continuing care provider does not imply that only prepayment arrangements are recognized. It means that the recipient or recipient's family has agreed to use one provider as the regular source of continuing care services for a stated period of time, and that the mutual obligations of both recipient and provider are recognized by signed enrollment agreements.

Enrollment by itself under capitation arrangements or prepaid health plans does not constitute a continuing care arrangement, nor does enrollment in specific categorical health clinics. Providers who furnish only screening services do not provide continuing care.

Use of continuing care providers is encouraged in the belief that they can help both improve the delivery and quality of services and contain costs.

B. **Requirements.**--A continuing care provider is one who formally agrees: to provide to individuals formally enrolled, screening, diagnosis, and treatment for conditions identified during screening (within the provider's capacity) or referral to a provider capable of providing the appropriate services; maintains a complete health history, including information received from other providers; is responsible for providing needed physician services for acute, episodic and/or chronic illnesses and conditions; and ensures accountability by submitting reports reasonably required by the State agency.

A continuing care provider functions as the health care manager, performing the entire set of EPSDT functions. Providing screening, information, and referral services is part of but does not constitute the complete continuing care set.

Continuing care providers may have to arrange for certain specialty services that are beyond the scope of their practice (e.g., cardiology or ophthalmology); and may agree, at its option, to provide dental services or to make direct dental referrals. The provider must specify in the agreement whether dental services are provided. If the provider does not choose to provide either service, it must refer recipients to the State agency to obtain required dental services.

Similarly, the continuing care provider may agree, at its option, to provide all or part of required transportation and scheduling assistance and specify the transportation and scheduling assistance to be furnished. If the provider does not choose to provide this assistance, it must refer recipients to the State agency.

The continuing care provider may agree to provide recipients with assistance in referrals for services not covered under the Medicaid program. If the provider does not choose to provide this assistance, it must refer recipients to the State agency.

When utilizing continuing care providers, maintain a description of the services provided and assure the providers' compliance with their agreement. HCFA does not specify the content of monitoring protocols, since the design use, evaluation and redesign of monitoring methods are essential elements of your program management. However, specify in the State plan the methods you use to assure that continuing care providers comply with their agreements.

You are responsible for ensuring that there is adequate tracking or case management. Tracking is included in the services which continuing care providers are required to furnish. Employ performance standards, expressed in continuing care agreements, required reports, and monitoring criteria.

The costs of continuing care services are Medicaid costs. Negotiate them on a fee-for-service, fee-for-time or capitation basis.

The agency is deemed to have met EPSDT requirements for participants enrolled with a continuing care provider. "Deeming" is dependent on all other EPSDT program requirements being met. Do not use continuing care providers as a way of dropping responsibility to provide services to eligible children. Do not categorically declare that all children are enrolled with these providers.

You have enhanced flexibility to achieve your desired child health program goals through the use of continuing care providers. Implementing the continuing care option can ease administrative burdens as the provider becomes the case or medical manager. This allows States to monitor a continuing care provider and the services delivered rather than monitoring each enrolled participant.

Administration

5310. PROGRAM MONITORING, PLANNING, AND EVALUATION

A. **General.**--Establish administrative procedures to identify facilities for examination (screening), diagnosis, and treatment; assure that recipients receive the services of those facilities; and assure that services covered under Medicaid are available.

When facilities or providers who are willing to participate have been identified and have met applicable requirements, provider agreements cannot be denied unless there is good cause. The provider must agree to keep records necessary to disclose the extent of services furnished and information regarding payment claims.

When examination and diagnostic resources throughout the State are insufficient to meet adequately the needs of the program, encourage the development of additional centers. Medical and dental societies, other practitioner organizations, medical and dental schools, State, regional, or local health departments, programs for mothers and children under title V of the Social Security Act, community health centers, developmental disability agencies, university affiliated facilities, day care centers, school health programs, rehabilitation agencies, and voluntary health organizations can be helpful.

Inform recipients about and provide EPSDT services if requested, i.e., screenings, examinations, diagnosis, and treatment. Provide subsequent EPSDT services according to a periodicity schedule which specifies services applicable at each stage of the beneficiary's life, until the age when eligibility ends.

Assure that a participating child is periodically screened and treated in conformity with the schedule and State set timeliness standards. To comply with this requirement, design and employ policies and methods to assure that children receive rescreening and treatment when due. If the family requests assistance with necessary transportation and scheduling to receive Medicaid services, provide it.

Set standards for the timely provision of screening and treatment services which meet reasonable standards of medical and dental practice, as determined after consultation with recognized medical and dental organizations involved in child health care.

Design and employ methods to assure that children receive (1) those screening services initially or periodically requested or due under the periodicity schedule and (2) treatment for all conditions identified as a result of examination or diagnosis.

Consider an initial examination of a newborn determined eligible for Medicaid as an initial examination for purposes of identifying a child as participating in the program.

Consider a recipient receiving services to be participating. This is true whether the recipient has requested services directly from you or elsewhere (e.g., walk-ins) and applies both for initially requested services and all services due under the periodicity schedule. Once you know that a recipient is participating, assure that the recipient receives timely delivery of services for the next encounter under the periodicity schedule.

If an individual declined support services or elected to arrange his/her own appointment with a provider, assure that the individual receives services.

Consider treatment initiated when the child gets to the office for the encounter. It cannot be assumed that the date treatment was initiated is the same as the date the appointment was scheduled.

If a physician or facility provides some of the required screening components, assure provision of the remaining components requested by the family or recipient. If a recipient accepts only specific components, document declination of the others.

B. Providing for EPSDT Services.--When services are requested, provide them in conformity with the established periodicity schedule and timeliness standards. Timeliness standards for initiation of treatment, if required, generally have an outer limit of 6 months after the request for screening services.

If an individual chooses a non-Medicaid provider, it is not a declination of services. Assure recipients of their freedom of choice of provider and inform them of the financial consequences of their choice. Only screening components and treatment services requested of a Medicaid provider need to be monitored or reimbursed.

The designation of a primary physician by an individual recipient may be required when overutilization of covered services is confirmed and when efforts to solicit voluntary cooperation have failed. Make provision to allow change in primary physician designation at least every three months or immediately upon demonstration by the recipient of good cause.

Allow HMO enrollees to receive services from their HMO provider if they are included as part of the contract. If the contract does not include EPSDT services, assure the beneficiary timely delivery of requested services.

C. Reasonable Standards of Medical and Dental Practice.--Effective EPSDT program design and implementation requires continuing involvement of health professional organizations. Screening protocols and services, periodicity schedules, and service delivery timeliness standards must meet reasonable standards of medical and dental practice, determined by the agency after consultation with recognized medical and dental organizations involved in child health care.

The term, "reasonable standards of medical and dental practice," gives States flexibility to weigh different factors, yet precludes inappropriate standards. Health practice standards based on professional judgements are an essential factor.

In determining program standards, consult with recognized organizations, knowledgeable about the general health, growth, development and nutritional status of infants, children and youth. HCFA accepts these determinations as long as they meet reasonable medical and dental practice standards.

The input and assessment of health professional organizations is required and is vital to ensure that State standards are reasonable in terms of medical and dental practice. Although medical care advisory committees are required to advise Medicaid agencies about health and medical care services, and can provide a framework for consultation, they can not substitute for recognized medical and dental organizations involved in child health care.

Maintain a dialogue with such organizations in order to ensure that the standards reflect current professional judgement.

D. Case Management.--Case management is an activity under which responsibilities for locating, coordinating and monitoring necessary and appropriate services for a recipient rests with a specific individual or organization. See Part 4, §4302.

In EPSDT, it centers on the process of collecting information on the health needs of the child, making (and following up on) referrals as needed, maintaining a health history, and activating the examination/diagnosis/treatment "loop."

Case management provides the difference between a fragmented program in which examinations, diagnosis, treatment, and other functions are performed in isolation from each other, and a comprehensive program based on the concept of getting children into the existing "mainstream" system of health care delivery.

Notifying recipients of the time they are due to receive a screening service is an integral part of your responsibility and an essential part of case management. As individual recipients approach age levels when an EPSDT screening is due, notify them that it is the appropriate time to receive services. For recipients enrolled with a continuing care provider, the provider furnishes that notification.

5320. INFORMATION NEEDS AND REPORTING

HCFA has developed simplified methods to collect information on program activities in order to assure that the goals are met. Maintain records, program manuals, rules and procedures describing the methods used to assure that services are provided appropriately and timely.

- o Information must be available at the agency or local office.
- o Keep information needed to assess compliance with Federal Medicaid requirements for a minimum of 3 years.
- o At the time of review, the reviewer provides the agency with an opportunity to supply any missing data before reaching a finding of non-compliance.
- o Determine the nature of the record system. A computer system may be used from which individual case histories can be retrieved if such a system is appropriate and efficient in program administration.

5320.1 Administrative Information Requirements.--The input and assessment of the health professions organizations is vital to validate existing State standards. Agency records must demonstrate that there has been consultation with professional organizations in developing periodicity schedules that are reasonable in terms of medical and dental practice. They also demonstrate how conflicting recommendations or factors were weighed and resolved in order to best serve the needs of a particular State and its EPSDT participants.

Written informing materials for recipients may be contained in one document or in several. The choice of words for explaining the benefits of preventive services and the components of the screening package is optional, but must be in clear and nontechnical language.

Rules and procedures for informing the illiterate, blind, deaf, or those unable to understand the English language are discretionary. However, the agency's records must describe how these individuals are informed and demonstrate that the rules and procedures employed are effective.

5320.2 Records or Information on Services and Recipients.--You must have descriptions of the processes and procedures used for initial informing and how the procedures are monitored. Written informing may be accomplished through computerized mailing, verified by a computer print-out.

Although each case record contains information on informing, written procedures can be used to supplement the documentation.

Where proof of written informing is a computerized print-out, it must indicate the materials mailed, the date the mailing occurred and identify to whom they were sent.

Through program manuals, records, rules, and procedures, you must be able to demonstrate that processes are in place to effectively inform individuals about EPSDT. The procedures must support a determination that informing occurs generally within 60 days of the individual's eligibility determination and, for families which have not used EPSDT services, annually thereafter.

The program manuals, records, rules, and procedures that describe the informing process and content of oral informing must provide sufficient detail to permit a reviewer to determine that required information is delivered. Records generated by agency management activities give you the opportunity to demonstrate that the required procedures are used and that the informing services are effective.

A. Families or Recipients Who Decline EPSDT Services.--Acceptable documentation of a declination of EPSDT services for a family in which at least one member has received EPSDT services or is being tracked under the periodicity schedule is verification of an oral or a written statement that all members of the family no longer wish to participate in the EPSDT program.

Information must be available to show that the recipient either declined services, gave an undecided response, or failed to respond to an offer of services. An undecided or nonresponse is a declination of that periodic examination and not a declination of EPSDT services.

Documentation of the offer may be a dated copy of a letter or form sent to the recipient or a dated record of an in-person or telephone contact. A declination or an undecided response may be a turnaround document, a dated statement from the family (the date of receipt by the agency is the date of declination), or dated documentation of the beneficiary's response to an in-person or telephone contact. A nonresponse may be documented via the absence of a form of recipient response.

If a recipient accepts only specific components of EPSDT, record the components requested to assure that they are provided.

A declination of support services or a failure to respond to specific service scheduling or referral constitutes a declination of that specific periodic service and does not in itself constitute a declination of EPSDT services.

B. Services.--Information must be available showing that all applicable services were provided. Acceptable forms of computerized or manual verification include:

- o A provider's claim form itemizing each service given, refused, or medically contraindicated, the date of service(s), and any conditions needing treatment;
- o A provider's certification that the examination was provided, the date of service(s), and any conditions found needing treatment; and
- o Records of telephone contacts with providers to ascertain that services were provided, the date of service(s), and conditions discovered which required treatment.

When a claims form or provider certification is absent or does not provide contradictory evidence, the recipient's documentation that an examination was received is acceptable. Documentation must be made of any conditions found needing treatment.

When arrangements are made with continuing care providers, whether they are private physicians, HMOs, title V grantees, Indian Health Service clinics, hospitals, or group medical practices for the delivery of EPSDT services, assure compliance with the EPSDT program. Records must be available for your auditing. You provide the methods to be used.

C. Program Reports.--See Part 2, §2700.4. The annual report (Form HCFA-416) contains the following data on EPSDT services provided to children during the previous Federal fiscal year, by age groups (under 1, 1-5, 6-14, 15-20) and categorically or medically needy classification:

- o Number of individuals eligible for EPSDT;
- o Ratio of recommended initial or periodic screening services per age group member;
- o Average period of eligibility;
- o Adjusted ratio of recommended initial or periodic screening services per age group member;
- o Proportion of eligibles who should receive at least one initial or periodic screening service;
- o Number of eligibles who should receive at least one initial or periodic screening service;
- o Number of eligibles receiving at least one initial or periodic screening service;
- o Participant ratio;
- o Expected number of initial and periodic screening services;
- o Actual number of initial and periodic screening services;
- o Screening ratio;
- o Number of eligibles referred for corrective treatment;
- o Number of eligibles receiving vision assessments;
- o Number of eligibles receiving dental assessments;
- o Number of eligibles receiving hearing assessments; and
- o Total number of eligibles enrolled in continuing care arrangements.

State managers may collect and analyze more detailed information about eligible children, their services utilization and health status, as part of ongoing program evaluation and planning. Examples of this information include:

- o Number of individuals, under health supervision, for whom examinations were not due according to your periodicity schedule;
- o Number of individuals found with health problems for whom treatment was initiated during a given time period;
- o Major health problems and their relative significance;
- o Provider participation, practice and utilization patterns;
- o Geographic and demographic utilization analyses to determine outreach or health problem targets; and
- o Costs and effects studies comparing the Medicaid expenditure experience of participants and nonparticipants.

5330. TIMELINESS

Set standards for the timely provision of services, which meet reasonable standards of medical and dental practice, as determined after consultation with recognized medical and dental organizations involved in child health care. Employ processes to:

- o Effectively inform individuals, generally, within 60 days of the individual's eligibility determination and, in the case of families that have not utilized services, annually thereafter;
- o Ensure timely initiation of treatment, generally within an outer limit of 6 months after a request for screening services;
- o Substantiate mandated consultations in determining standards through correspondence or meeting records. Memoranda describing advantages and disadvantages of suggested standards can show how you considered and resolved conflicting standards in order to best serve the needs of your particular State and participants.
- o Demonstrate that the required standards are employed through reports on numbers, or lists, of recipients overdue for services and the actions taken to assure the provision of needed identified services.

5340. REIMBURSEMENT

A. General Information.--Any service provided to EPSDT eligibles covered under the EPSDT program may be reimbursed under Medicaid, even if it is mandated by another agency or available as a community health service.

Medicaid provides financial access to health care services for individuals determined unable to pay for them, assures availability and delivery of EPSDT services, provides or arranges for covered services, and pays for them unless the beneficiary has liable third party coverage or the services are provided free of charge. Third party resources include Medicare (title XVIII), Railroad Retirement Act, insurance policies (private health, group health, liability, automobile, or family health insurance carried by an absent parent), Workers' Compensation, Veterans Administration Benefits, and Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

Except for title V services, it is Medicaid policy that services which are available without charge to all individuals in the community may not be reimbursed. Services without charge, for purposes of Medicaid, means that no individual or family is charged for medical care and third party reimbursement is not sought.

The law requires the provision of the services needed by EPSDT clients if the services can be covered under the Medicaid program. Coordination of services to maximize treatment of clients is an essential aspect of the EPSDT program. Therefore, programs which enter into written interagency and/or provider agreements with the Medicaid agency to provide a service mandated on that agency, must specify the terms of reimbursement in such agreements.

The following conditions must be met if Medicaid is to be billed for medical services provided by other agencies or programs financed by Federal and State funds:

- o A fee schedule is established for each service billed to Medicaid; and
- o Information on third party liable resources is obtained from each Medicaid beneficiary, and billing of all third party liable resources is documented.

B. Services.--Provide payment for screening, vision, hearing, and dental services as well as for other health care, diagnostic, treatment, or other measures which are necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services.

Provide payment for diagnosis and treatment services and continuing medical treatment after an initial referral if medically necessary.

Agreements with other agencies, such as title V grantees, may provide for payment mechanisms that are used for other providers, including the Medicaid fee schedule and reasonable charge structures. Limit reimbursement of overhead costs under interagency agreements to costs identifiable as supporting EPSDT Medicaid services.

Cooperative agreements or contracts with other agencies and programs, such as title V, may include payment for certain administrative functions (e.g., outreach, assessing quality, transportation, and case management).

Seventy-five percent Federal matching is available for the cost of skilled professional medical personnel and directly supporting staff employed by the title XIX agency or other public agency if they meet the requirements of 42 CFR 432.50.

C. Transportation.--Assurance of transportation necessary to secure medical examinations and treatment is a mandatory State plan requirement. Provide transportation of EPSDT participants through Medicaid or cooperative agreements with voluntary and public organizations and with the recipient's family members and friends. You may finance these services through title XX, for example.

If you choose to provide transportation through Medicaid, claim expenditures in accordance with 42 CFR 440.170.

Transportation is recognized as an optional medical service only when furnished by a provider to whom you may make a direct vendor payment, such as an ambulance company. In this instance, claim FFP for transportation of eligible recipients at the applicable Federal medical assistance percentage (FMAP) as a Medicaid service only if you are able to document your claim as any other claim for eligible Medicaid services (i.e., provider agreement, provider number, date of service, eligible recipient, type of service). If you are unable to document the claim as a Medicaid service, reimbursement is not allowed. However, if you make other arrangements to assure transportation, FFP is available as an administrative cost.

Transportation is further defined to include related travel expenses, a term intended to cover other than routine situations. For example, an EPSDT participant may require a particular medical service which is only available in another city, county, or State, and the distance and travel time may warrant staying in that place overnight. Related travel expenses may include the recipient's lodging and meals en route to and from the facility and, if medically necessary, the cost of an attendant to accompany the recipient. The attendant's costs may include transportation, lodging, meals, and salary. However, Federal matching is not available to pay a salary to an attendant who is a member of the recipient's family.

FFP is not available for the advance of capital funds to purchase transportation vehicles.

5350. CONFIDENTIALITY

A. General.--The use or disclosure of information concerning applicants and recipients is restricted to purposes directly related to administration of the title XIX State plan. Medicaid's EPSDT program requires you to provide services for recipients. Since §1905(a)(4)(B) of the Act requires the provision of these services, consider them as activities directly connected with the administration of the plan. Outreach, informing, and assistance with transportation and scheduling appointments for services are also considered activities directly related to State plan administration. Medical information is privileged and may only be released with the patient's permission.

Any agency or provider having a written interagency or provider agreement to perform EPSDT services that include outreach activities and/or assistance with transportation or scheduling appointments is considered an extension or arm of the Medicaid agency. Without his/her consent, an individual's name, address, medical assistance number, and related information may be furnished to such an agency or provider that meets the other confidentiality requirements listed below.

B. Confidentiality Requirements.--The following confidentiality requirements must be met:

- o Criteria must specify the conditions for release and use of information about applicants and recipients;

- o Information access is restricted to persons or agency representatives subject to legal sanctions or standards of confidentiality at least comparable to those of the Medicaid agency;

- o The release of names of applicants and recipients which may be used by outside sources (sources not under agreement with the agency to provide EPSDT services for recipients) is prohibited; and

- o Written permission is obtained from a family or individual before responding to a request for information from an outside source.

Information may be exchanged when the agency is located within the State structure if the regulatory requirements for safeguarding information on applicants and recipients are met.

5360. ANNUAL PARTICIPATION GOALS

A. General.--Section 1905(r) of the Act mandates setting annual participation goals not later than July 1 of each year for participation by eligible individuals in your State in early and periodic screening, diagnostic and treatment services. Your annual report on provision of EPSDT (Form HCFA-416) provides data with which to assess your results in attaining those goals.

B. Participant Ratio.--This ratio indicates the extent to which the number of eligibles who should be screened during the year receive at least one initial or periodic screening service. (See §1122.A.)

The unit of measure is the number of eligibles receiving at least one initial or periodic screening service (see line 7 of Form HCFA-416) divided by the unduplicated count of eligibles who should receive at least one initial or periodic screening service. (See line 6 of Form HCFA-416 described in §2700.4.) The unduplicated count of eligibles who should receive at least one initial or periodic screening service is the number of individuals eligible for EPSDT (see line 1 of Form HCFA-416) adjusted based on the Guidelines for Health Supervision of the American Academy of Pediatrics' (AAP) recommended periodicity schedule and the average period of eligibility in each State.

The goal is for each State to achieve an 80-percent EPSDT participant ratio within 5 years or by FY 1995.

Interval goals are included in Exhibit A. In FY 1989, a proxy measure of State EPSDT participation rates (the number of eligibles enrolled in continuing care arrangements plus the number of initial/periodic screening examinations divided by total eligibles) ranged from 7 percent to 96 percent. You are expected to reduce the difference between current performance and the 80-percent goal by one-fifth each year from FY 1991 through FY 1995. If your program already meets the 80-percent target, no higher goals are set.

C. Screening Ratio.--This ratio indicates the extent to which eligibles receive the number of initial and periodic screening services expected.

The unit of measure is the actual number of initial and periodic screening services (see line 10 of Form HCFA-416) divided by the expected number of initial and periodic screening services. (See line 9.) The expected number of initial and periodic screening services for the number of EPSDT eligibles is reported based on the periodicity schedule recommended in the AAP's Guidelines for Health Supervision and the average period of eligibility in each State.

The AAP recommended periodicity schedule calls for the following number of screening services by age group (or health supervision examinations, as the AAP calls them):

- o Under 1 (i.e., 0-12 months): 6 (at or by 1, 2, 4, 6, 9, and 12 months);
- o 1 - 5: 6 (at or by 15, 18, and 24 months, and 3, 4, and 5 years);
- o 6 - 14: 5 (at or by 6, 8, 10, 12, and 14 years); or
- o 15 - 20: 3 (at or by 16, 18, and 20 years)

Therefore, the annual numbers of screening services visits expected per age group member, are:

Age Group	Visits	Years per Age Group	Visits Per Age Group Member
Under 1	6	1	6.00
1 - 5	6	5	1.20
6 - 14	5	9	0.56
15 - 20	3	6	0.50

To determine the number of screening services that fully meet the AAP recommendation, multiply the visits per age group member by the estimated number of EPSDT eligibles for each age group.

The goal is for you to achieve, within 5 years or by FY 1995, 80 percent of the expected number of initial and periodic screening services for the number of EPSDT eligibles reported based on the periodicity schedule recommended in the Guidelines for Health Supervision of the AAP and the average period of eligibility in each State. No interval goals have been set.

D. Complete Screening Services. Report a participant as having received screening services (see line 7 of Form HCFA-416) or a screening service as having been received (see line 10 of Form HCFA-416) only if the following complete set of activities comprising a screening service has been furnished:

- o A comprehensive health and developmental history (including assessment of both physical and mental health development);
- o A comprehensive unclothed physical exam;
- o Appropriate immunizations according to age and health history (unless medically contraindicated at the time);
- o Laboratory tests (including lead blood level assessment appropriate for age and risk factors); and
- o Health education (including anticipatory guidance).

Do not report those participants who receive some (but not all) screening service activities, or those who receive interperiodic, vision, hearing, or dental services.

EXHIBIT A

EXPECTED IMPROVEMENT IN EPSDT PARTICIPATION

	1989 Proxy Rate*	% Points Needed	Interval Goals by Fiscal Year				
			1991	1992	1993	1994	1995
Alabama	40%	40%	48%	56%	64%	72%	80%
Alaska	70%	10%	72%	74%	76%	78%	80%
Arizona	96%	--	96%	96%	96%	96%	96%
Arkansas	28%	52%	38%	49%	59%	70%	80%
California	63%	17%	66%	70%	73%	77%	80%
Colorado	94%	--	94%	94%	94%	94%	94%
Connecticut	10%	70%	24%	38%	52%	66%	80%
Delaware	7%	73%	22%	36%	51%	65%	80%
Dis of Columbia	24%	56%	35%	46%	58%	69%	80%
Florida	67%	13%	70%	72%	75%	77%	80%
Georgia	44%	36%	51%	58%	66%	73%	80%
Hawaii	28%	52%	38%	49%	59%	70%	80%
Idaho	12%	68%	26%	39%	53%	66%	80%
Illinois	57%	23%	62%	66%	71%	75%	80%
Indiana	9%	71%	23%	37%	52%	66%	80%
Iowa	9%	71%	23%	37%	52%	66%	80%
Kansas	13%	67%	26%	40%	53%	67%	80%
Kentucky	13%	67%	26%	40%	53%	67%	80%
Louisiana	33%	47%	42%	52%	61%	71%	80%
Maine	55%	25%	60%	65%	70%	75%	80%
Maryland	49%	31%	55%	61%	68%	74%	80%
Massachusetts	61%	19%	65%	69%	72%	76%	80%
Michigan	48%	32%	54%	61%	67%	74%	80%
Minnesota	34%	46%	43%	52%	62%	71%	80%
Mississippi	33%	47%	42%	52%	61%	71%	80%
Missouri	37%	43%	46%	54%	63%	71%	80%
Montana	42%	38%	50%	57%	65%	72%	80%
Nebraska	57%	23%	62%	66%	71%	75%	80%
Nevada	62%	18%	66%	68%	73%	76%	80%
New Hampshire	15%	65%	28%	41%	54%	67%	80%
New Jersey	11%	69%	25%	39%	52%	66%	80%
New Mexico	35%	45%	44%	53%	62%	71%	80%
New York	15%	65%	28%	41%	54%	67%	80%
North Carolina	54%	26%	59%	64%	70%	75%	80%
North Dakota	19%	61%	31%	43%	56%	68%	80%
Ohio	49%	31%	55%	61%	68%	74%	80%
Oklahoma	7%	73%	22%	36%	51%	65%	80%
Oregon	43%	37%	50%	58%	65%	73%	80%
Pennsylvania	44%	36%	51%	58%	66%	73%	80%
Rhode Island	45%	35%	52%	59%	66%	73%	80%
South Carolina	79%	1%	79%	79%	80%	80%	80%
South Dakota	21%	59%	33%	45%	56%	68%	80%
Tennessee	27%	53%	38%	48%	59%	69%	80%
Texas	24%	56%	35%	46%	58%	69%	80%
Utah	32%	48%	42%	51%	61%	70%	80%
Vermont	68%	12%	70%	73%	75%	78%	80%
Virginia	52%	28%	58%	63%	69%	74%	80%
Washington	35%	45%	44%	53%	62%	71%	80%
West Virginia	56%	24%	61%	66%	70%	75%	80%
Wisconsin	47%	33%	54%	60%	67%	73%	80%
Wyoming	27%	53%	38%	48%	59%	69%	80%
	39%	41%	47%	56%	64%	72%	80%

* Fiscal year 1989 ratio of continuing care enrollees and initial and/or periodic screening examinations to the average number of eligibles.

Source: Form HCFA-420.